Chapter 97. Long-Term Care Insurance.

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Subchapter 1. General Provisions.

[Reserved]

Subchapter 2. Long-Term Care Insurance Act.

23-97-201. Short title.

This subchapter may be known and cited as the "Long-Term Care Insurance Act".

23-97-202. Purpose.

The purpose of this subchapter is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

23-97-203. Definitions.

Unless the context requires otherwise, the definitions in this section apply throughout this subchapter:

- (1) "Applicant" means:
 - (A) In the case of an individual long-term care insurance policy, the person who

- seeks to contract for benefits; and
- (B) In the case of a group long-term care insurance policy, the proposed certificate holder;
- (2) "Certificate" means, for the purposes of this subchapter, any certificate of insurance or evidence of coverage issued to a resident of this state regardless of the state in which the policy was issued;
- (3) "Commissioner" means the Insurance Commissioner;
- (4) "Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in this state and issued to:
 - (A) One (1) or more employers or labor organizations, or to a trust or to the trustees of a fund established by one (1) or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organization; or
 - (B) Any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if such association:
 - (i) Is composed of individuals, all of whom are or were actively engaged in the same profession, trade, or occupation; and
 - (ii) Has been maintained in good faith for purposes other than obtaining insurance; or
 - (C)(i) An association or a trust or the trustee or trustees of a fund established, created, or maintained for the benefit of members of one (1) or more associations.
 - (ii) Prior to advertising, marketing, or offering such policy or contract within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the commissioner that the association or associations:
 - (a) Have at the outset a minimum of one hundred (100) persons;
 - (b) Have been organized and maintained in good faith for purposes other than that of obtaining insurance;
 - (c) Have been in active existence for at least one (1) year; and
 - (d) Have a constitution and bylaws which provide that:
- (1) The association or associations hold regular meetings not less than annually to further purposes of the members;
- (2) Except for credit unions, the association or associations collect dues or solicit contributions from members; and
- (3) The members have voting privileges and representation on the governing board and committees.
 - (iii) Thirty (30) days after such filing, the association or associations will be deemed to satisfy such organizational requirements, unless the commissioner makes a finding that the association or associations do not satisfy those organizational requirements; or
 - (D) A group other than as described in subdivisions (4)(A), (4)(B) and (4)(C) of this section, subject to a finding by the commissioner that:

- (i) The issuance of the group policy is not contrary to the best interest of the public;
- (ii) The issuance of the group policy would result in economies of acquisition or administration; and
- (iii) The benefits are reasonable in relation to the premiums charged;
- (5)(A)(i) "Long-term care insurance" means any insurance policy, contract certificate, rider, or other evidence of coverage issued, issued for delivery, advertised, marketed, or offered in this state to provide coverage for not less than twelve (12) consecutive months for each covered person, on an expense-incurred, indemnity, prepaid, or other basis, for one (1) or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital.
 - (ii) The term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance. The term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term shall also include qualified long-term care insurance contracts.
 - (iii) Long-term care insurance may be issued by insurers, fraternal benefits societies, nonprofit hospital and medical service corporations, prepaid health plans, health maintenance organizations, or any similar organization to the extent they are otherwise authorized to issue life or accident and health insurance.
 - (B)(i) Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident-only coverage, specified disease or specified accident coverage, or limited benefit health coverage.
 - (ii) With regard to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for one (1) or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.
 - (iii) Notwithstanding any other provision contained herein, any product advertised, marketed, or offered as long-term care insurance shall be subject to the provisions of this subchapter;
- (6) "Policy" means, for the purposes of this subchapter, any policy, contract, subscriber agreement, certificate, rider, or endorsement or other evidence of coverage delivered or issued for delivery in this state by an issuer, fraternal benefit society, nonprofit hospital or medical service corporation, prepaid health plan, health maintenance organization, or similar organization;

- (7) "Qualified long-term care insurance contract" means any individual or group insurance contract if it meets the requirements of Section 7702B of the Internal Revenue Code, as amended, and if:
 - (A) The only insurance protection provided under the contract is coverage of qualified long-term care services;
 - (B) The contract does not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under Title XVIII of the Social Security Act, as amended, or would be so reimbursable but for the application of a deductible or coinsurance amount. This subdivision (7)(B) does not apply to a contract that makes per diem or other periodic payment without regard to expenses;
 - (C) The contract is guaranteed renewable;
 - (D) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed. All refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund of the aggregate premium paid under the contract may be allowed in the event of the death of the insured or a complete surrender or cancellation of the contract; and
 - (E) The contract contains the consumer protection provisions set forth in Section 7702B(g) of the Internal Revenue Code;
- (8) "Qualified long-term care insurance contract" also means any life insurance contract which provides long-term care coverage by rider or as part of the contract as long as the contract complies with the applicable provisions of section 7702B of the Internal Revenue Code, as amended; and
- (9) "Qualified long-term care services" means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance for personal care services for which an insured is eligible under a qualified long-term care insurance contract, and which are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

23-97-204. Scope.

The requirements of this subchapter shall apply to policies delivered or issued for delivery in this state on July 1, 1997. This subchapter is not intended to supersede the obligations of entities subject to this subchapter to comply with the substance of other applicable insurance laws insofar as they do not conflict with this subchapter, except that laws and regulations designed and intended to apply to medicare supplement insurance policies shall not be applied to long-term care insurance.

23-97-205. Required compliance.

No policy or contract may be advertised, marketed, or offered as long-term care or nursing home insurance in this state unless it complies with the provisions of this subchapter.

23-97-206. Administrative procedures.

Regulations adopted pursuant to this subchapter shall be in accordance with the provisions of § 23-61-108 and § 25-15-201 et seq.

23-97-207. Group long-term insurance.

No group long-term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in § 23-97-203(4)(D), unless the Insurance Commissioner has determined that the group policy meets the requirements of § 23-97-203(4)(D).

23-97-208. Disclosure and performance standards for long-term care insurance.

- (a) The Insurance Commissioner may adopt regulations that include standards for full and fair disclosure, setting forth the manner, content, and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definitions of terms.
- (b) No long-term care insurance policy may:
 - (1) Be cancelled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder; or
 - (2) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or
 - (3) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.
- (c) The commissioner may adopt regulations establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the regulation.
- (d) **Monthly Reports.** Any time a long-term care benefit funded through a life insurance vehicle by the acceleration of the death benefit is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include:
 - (1) Any long-term care benefits paid out during the month;
 - (2) An explanation of any changes in the policy, e.g., death benefits or cash values, due to long-term care benefits being paid out; and
 - (3) The amount of long-term care benefits existing or remaining.
- (e) **Claim Denials.** If a claim under a qualified long-term care insurance contract is denied, the issuer shall, within sixty (60) days of the date of a written request by the policyholder or certificate holder, or a representative thereof:
 - (1) Provide a written explanation of the reasons for the denial; and
 - (2) Make available all information directly related to such denial.
- (f) Incontestability Periods.

- (1) For a policy or certificate that has been in force for less than six (6) months an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance of the coverage.
- (2) For a policy or certificate that has been in force for at least six (6) months but less than two (2) years, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.
- (3) After a policy or certificate has been in force for two (2) years it is not contestable upon the grounds of misrepresentation alone; such policy or certificate may be only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

(g) Field Issued Policies.

- (1) No long-term care insurance policy or certificate may be field issued based upon medical or health status.
- (2) For purposes of this section, "field issued" means a policy or certificate issued by an agent or a third-party administrator pursuant to the underwriting authority granted to the agent or third-party administrator by an insurer.
- (h) **Policy Rescissions.** If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments may not be recovered by the event that the policy or certificate is rescinded.

(i) Nonforfeiture Benefits.

- (1) No long-term care insurance policy or certificate may be delivered or issued for delivery in this state unless the policyholder at the time of the application is offered the option of purchasing a policy or certificate that provides for nonforfeiture benefits to the defaulting or surrendering policyholder or certificate holder. The commissioner shall promulgate a regulation specifying the type or types of nonforfeiture benefits to be included in such policies and certificates and the standards for the benefits.
- (2) Nonforfeiture benefits for qualified long-term care insurance contracts shall offer at least a reduced paid-up insurance benefit, an extended term insurance benefit, the offer of a short-ended benefit period, or other similar offerings approved by the United States Secretary of the Treasury, and shall be provided as specified in regulations. The issuer of the contract may refund premiums upon death of the insured or upon complete surrender or cancellation of the contract or policy, as long as the refund does not exceed the aggregate premiums paid for the contract or policy.

23-97-209. Preexisting condition.

(a)(1) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in § 23-97-203(4)(A) shall use a definition of "preexisting condition" which is more restrictive than the following:

Preexisting condition means a condition for which medical advice or treatment was

recommended by, or received from, a provider of health care services within six (6) months preceding the effective date of coverage of an insured person.

- (2) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in § 23-97-203(4)(A) may exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six (6) months following the effective date of coverage of an insured person.
- (3) The Insurance Commissioner may extend the limitation periods set forth in this section as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.
- (4) The definition of "preexisting condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the applicant's answers on that application, conduct underwriting in accordance with that insurer's established underwriting standards.
- (b) Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subdivision (a)(2) of this section expires. No long-term insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in subdivision (a)(2) of this section.

23-97-210. Prior hospitalization or institutionalization.

- (a) Effective April 6, 1994, no long-term care insurance policy or certificate may be delivered or issued for delivery in this state if such policy or certificate:
 - (1) Conditions eligibility for any benefits on a prior hospitalization requirement;
 - (2) Conditions eligibility for benefits to be provided in an institutional care setting on the receipt of a higher level of institutional care; or
 - (3) Conditions eligibility for any benefits other than waiver of premium, postconfinement, post-acute care, or recuperative benefits on a prior institutionalization requirement.
- (b) Effective April 6, 1994, a long-term care insurance policy or certificate containing any limitations or conditions for eligibility specified in subdivision (a)(3) of this section shall clearly label in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits" such limitations or conditions, including any required number of days of confinement.
- (c) A long-term care insurance policy or certificate:
 - (1) Containing a benefit advertised, marketed, or offered as a home health care or home care benefit may not condition receipt of benefits on a prior institutionalization requirement;
 - (2) Which conditions eligibility of noninstitutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty (30) days for which benefits are paid; and
 - (3) Which provides for waiver of premium, postconfinement, post-acute care, or recuperative benefits only following institutionalization shall not condition such

benefits upon admission to a facility for the same or related conditions within a period of less than thirty (30) days after discharge from the institution.

23-97-211. Outline of coverage.

- (a)(1) A written outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation with a notice which prominently directs the attention of the recipient to the document and its purpose.
 - (2) The Insurance Commissioner shall prescribe a standard format for such outline, including style, arrangement, overall appearance, and content.
 - (3) In the case of agent solicitations, an agent must deliver the outline of coverage to the applicant prior to the presentation of an application or enrollment form.
 - (4) In the case of direct response solicitations, the outline of coverage must be presented to the applicant in conjunction with any application or enrollment form.
- (b) The outline of coverage shall include:
 - (1) A description of the principal benefits and coverage provided in the policy or certificate;
 - (2) A statement of the principal exclusions, reductions, and limitations contained in the policy or certificate;
 - (3) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of the issuer's right to change the premium. Continuation or conversion provisions of group coverage shall be specifically described;
 - (4) A statement in bold type that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;
 - (5) A description of the terms under which the policy or certificate may be returned and premium refunded; and
 - (6) A brief description of the relationship of cost of care to benefits.
- (c) If the policy or certificate is intended to be a qualified long-term care insurance contract, the outline of coverage shall also include a statement that discloses to the policyholder or certificate holder that the policy is intended to be a qualified long-term care insurance contract.

23-97-212. Certificates.

- (a) A certificate issued pursuant to a group long-term care insurance policy shall include:
 - (1) A description of the principal benefits and coverage provided in the policy;
 - (2) A statement of the principal exclusions, reductions, and limitations contained in the policy; and
 - (3) A statement that the group master policy determines governing contractual provisions.
- (b) The issuer of a qualified long-term care insurance contract shall deliver to the applicant, policyholder, or certificate holder the contract or certificate no later than thirty (30) days after the date of approval.

23-97-213. Right to return - Free look.

- (a)(1) Long-term care insurance applicants, policyholders, or certificate holders shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the entire premium refunded if, after examination of the policy or certificate, the policyholder or certificate holder is not satisfied for any reason.
 - (2)(A) Long-term care insurance policies and certificates shall be accompanied by a notice prominently printed on the first page or attached thereto stating in substance that the policyholder or certificate holders shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the entire premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in § 23-97-203(4)(A), the applicant or the policyholder is not satisfied for any reason.
 - (B) If an application for a qualified long-term care contract is denied, the issuer shall refund to the applicant any premium and any other fee submitted by the applicant within thirty (30) days of the denial.
- (b)(1) A person insured under a long-term care insurance policy issued pursuant to a direct response solicitation shall have the right to return the policy within thirty (30) days of its delivery and to have the entire premium refunded if, after examination, the insured person is not satisfied for any reason.
 - (2) Long-term care insurance policies issued pursuant to a direct response solicitation shall be accompanied by a notice prominently printed stating in substance that the insured person shall have the right to return the policy within thirty (30) days of its delivery and to have the premium refunded if, after examination, the insured person is not satisfied for any reason.